One Organization's Journey to Develop Leadership Competencies Related to Culture Change

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Key Messages

Healthcare is in a state of constant change. Leaders today must have the skills to manage change effectively. “Each manager must lead and each leader must manage … to respond to constant change and pressures both internal to and external to an organization” (Anderson, 1992, p. 54). Dickson and Tholl (2014) defined leadership in healthcare as “the collective capacity of an individual or group to influence people to work together to achieve a common constructive purpose: the health and wellness of the population we serve” (p. 17). Dickson and Tholl also asserted, “Leadership in health is often taken for granted, based on an implicit assumption that the competencies that make good leaders in the for-profit world can be imported wholesale to the complex world of healthcare” (p. vii), or that competent clinicians can automatically become effective leaders. Literature on the subject of healthcare leadership tends to focus on acute care settings such as hospitals or broader health systems. Few studies related to leadership have been written about the long-term care (LTC) or seniors’ housing (SH) sectors. This project contributes to health leadership knowledge by helping to inform LTC and SH executives where to focus to their attention to help leaders succeed in shifting a culture. This project benefits the residents of the organization, as staff provide more person-centred care as they are mentored by their leaders.

This paper reflects on the group experience of 12 leaders regarding a previous culture change initiative that failed and actions currently being taken to support leaders through a culture shift, to determine how to foster the capabilities required to be successful change agents in an LTC environment. Comparing and contrasting failures from the past and providing support and mentoring through a successful change process has resulted in enhanced leadership competencies within the organization and improved services to seniors.

Executive Summary

The Institute of Patient-and Family-Centred Care (n.d.) has defined resident-and family-centred care (RFCC) as an "approach to the planning, delivery, and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare providers, patients [residents], and families" (para. 1). Research evidence has shown that RFCC improves outcomes for residents in LTC and SH. In late 2014, the British Columbia (BC) provincial government directed all healthcare providers to implement patient-centred care (PCC). Accreditation Canada (n.d.) has taken the bold step of moving all sectors in healthcare forward towards RFCC by embedding PCC criteria within their standards in 2016.

The BC Patient Safety and Quality Council (BCPSQC) defined culture as "the way we think — our values, our perceptions and our beliefs. It's also about how we act — our habits and our typical behaviours. It's not about one person" (Frankel, Leonard, & Millman, 2017, p. 4). Culture has many aspects, both visible and invisible, including what staff members wear to work, how they communicate, what behaviours are accepted, how people are treated, leadership, as well as many unspoken rules. From the writer's 37 years of experience in the LTC sector, it is evident that culture is deeply entrenched in many organizations in the seniors' sector and is often difficult to change. A 65-year-old organization has multiple cultures and subcultures. Since 1953, the Mennonite Benevolent Society (MBS) has operated Menno Place (MP), home to 700 residents, in Abbotsford, BC, in six buildings on an 11-acre campus (Menno Place, n.d.-a). Oral history here indicates that change does not come easily and is often met with resistance. The board of MP adopted RFCC in its strategic framework in January 2015 (Menno Place, 2017; see Appendix A) and added additional goals to meet RFCC when the strategic plan was refreshed in 2018 (Menno Place, 2018).

Leadership development is crucial to support the people responsible for shifting organizational culture. As Bowers, Nolet, Roberts, and Esmond noted (2007), "Strong leadership is an important ingredient to any successful practice or organizational change. The more extensive the change, the more important leadership becomes. Taking on the role of change champion, leaders often make the difference between success and failure" (p. 5). Shifting MP's culture from the traditional medical or paternalistic model of "provider knows best" to the RFCC model requires bold leadership and support from the executive team.

The design of this project was both qualitative and quantitative. A literature review was undertaken on person-centred care, culture and the role of leadership in culture change, and leadership development for change management. Leaders were interviewed in focus groups and individually in the fall of 2013 to discuss their past change experiences related to a failed implementation of the Eden Alternative® (n.d.). The Eden Alternative was meant to reduce or eliminate loneliness, helplessness and boredom by changing the human habitat. The writer used a descriptive approach to examine the successes, failures, and lessons learned from that unsuccessful 3-year change initiative spanning 2007 to 2010 and recorded the actions being taken currently to support leaders to successfully shift the culture to RFCC and to provide knowledge about the competencies required for successful change management in LTC.

Training was undertaken to implement the LEADS in a Caring Environment (LEADS) framework (Cikaliuk, 2010; Dickson & Lindstrom, 2010) in the spring of 2014 to provide a common language about leadership capabilities. An evaluation of the effectiveness of the LEADS training and process was done using Kirkpatrick's (1998) model (Kirkpatrick, 1998). An electronic performance management software is being used to measure the growth in leadership capabilities of the leaders over time. The Accreditation Canada (Sounan, Lavigne, Lavoie-

Tremblay, Harripaul, Mitchell, MacDonald, 2012) Worklife Pulse tool was administered annually and results were analyzed to assess employees' perceptions about capabilities of the leadership team. An introduction of RFCC was initiated in January 2015. Using Frankel et al.'s (2017) *Culture Change Toolbox*, provided by the BCPSQC, a structured change process was implemented to shift the culture to RFCC. A clear understanding of the meaning of RFCC and a communication plan for implementation was vital to the success of the culture shift. Leading, assessing staff readiness, and sustaining culture change were areas identified as requiring analysis. Many authors described the importance of leadership, planning and step-by-step processes for successful culture shifts (Weiner and Ronch, 2003; Studer, 2013). The literature also indicated the need for ongoing personal development for leadership growth (Studer, 2013; Bolman & Deal, 2013; Covey, 1990; Dickson & Philippon, 2011: Dye, 2010). When making a large-scale change in philosophy, the literature identified the need to shift the culture of an organization and the importance of strong leadership (Weiner and Ronch, 2003; Argyris, 1993; Armenakis, Harris, & Mossholder, 2009; Baldwin & Linnea, 2010). The framework for change most commonly used within the writer's organization is Kotter's (1996, 2007) model.

The results of this project showed marked improvement in the leadership capabilities of the group following training on the LEADS framework (Dickson & Lindstrom, 2010; Folkman, 2015) and practical application of the framework. This project demonstrates that a formal investment in competency development for leaders can yield a positive result in the success of culture change in a relatively short time. Regular coaching and mentoring established the capacity of each individual and in the long run built the productivity of the organization.

The Report

Context

The Canadian Health Services Research Foundation (CHSRF) has a mandate to accelerate healthcare improvement and transformation. In a paper prepared for CHSRF, *Evidence-Informed Change Management in Canadian Healthcare Organizations*, Dickson, Lindstrom, Black, and Der Gucht (2012) stated that a major challenge of change management is that "it demands a flexibility of process and thinking … contrary to the traditional 'management' approaches that have previously been promoted" (p. 8). Constrained by legislative and regulatory boundaries, healthcare leaders often experience formal restrictions on creative thinking. The Canadian public, service providers, and politicians are acutely aware that healthcare leadership must make innovative system changes to ensure that services are sustainable and meet the needs of a growing and aging population. Systems transformation in healthcare can be slow, reactive, uncoordinated, unplanned, and awkward if strong leadership is lacking. This leads to the question, what competencies do strong leaders need to be successful?

Culture is often deeply entrenched in the long-term care (LTC) sector and this was the experience found in a research paper done at Menno Place (Zhou, 2010). Many complex care organizations have been attempting to shift from a rigid medical model with an emphasis on task-focused acute care practices to a holistic, person-centred model with a neighbourhood or home-like environment with the introduction of such programs as the Eden Alternative® (n.d.), Gentle Care© (Jones, 1998), and Person-Centred Care (Sawyer & Rurak, 2004; Love & Pinkowitz, 2013; Viau-Guay, Bellemare, Feilou, Trudel, Desrosiers & Robitaille, 2013; Young, 2017). In LTC, person-centred care is termed RFCC. Accreditation Canada (2015) defined RFCC as "an approach that fosters respectful, compassionate, culturally appropriate, and

competent care that is responsive to the needs, values, beliefs, and preferences of clients and their family members. It supports mutually beneficial partnerships between clients, families, and healthcare service providers" (p. 1).

Fiscal pressures have caused a reduction in the number of managers and directors in many LTC organizations, often leaving expanded roles for those left behind. Literature on the subject of organizational culture and change management articulated the significant role that leaders play as change agents:

> Effective leadership is essential to driving cultural change.… The best leaders are arguably the ones who are continuously monitoring their external and internal environments so that they understand what needs to be changed and how they should go about it (Weiner & Ronch, 2003, p. 24).

The BC Patient Safety and Quality Council booklet, Culture Change Toolbox – Residential Care (Frankel et al., 2017), has listed the components of a strong culture as "teamwork and communication, safety climate, psychological safety, organizational fairness, just culture, stress recognition, working conditions, leadership, learning and improvement, residents as partners and transparency" (p. 6).

The BC government has developed a health systems strategy to transform the health services that are being provided in the province. In its February 2014 document, titled *Setting Priorities for the BC Health System*, the BC Ministry of Health (BCMOH) stated,

> Patient-centred care will be the foundational driver in the planning and implementation of all strategic actions in the health system strategy. The province will strive to deliver healthcare as a service built around the individual, not the provider and administration (p. 27).

Revolutionary adjustments are required in service, care provision, and approaches to transform the organization's culture to be person centred. Person-centred care is a philosophy that can look very different to each person, and a clear understanding of what it means to the organization is critical to achieve a successful adoption of person-centred care (Li & Porock, 2014, p. 1395). The MP Board of Directors endorsed the 2014 provincial strategy and recognized the importance of moving the organization toward a person-centred vision. In response to the identification of a desire for this culture shift, the board added "Leadership" as a driver to its strategic framework in 2015; other drivers include People, Service, Quality, Safety, and Sustainability (Menno Place, 2017b; see Appendix A). As Studer (2013) noted,

> Successful organizations need a dependable process for educating their leaders and enhancing skills needed to drive organizational outcomes.… In order for an organization to be great, it has to have great leaders. In order to have great leaders, the organization has to invest in them (p. 151).

Administrators need to invest in leadership competency development to support their leaders, not just presume that because they have been "doing a job" that they have the capabilities to lead change well. The question remains, how can the organization ensure its leaders have the competencies to lead this culture shift?

The online Business Dictionary defines competencies as follows:

> A cluster of related abilities, commitments, knowledge, and skills that enable a person (or an organization) to act effectively in a job or situation. Competence indicates sufficiency of knowledge and skills that enable someone to act in a wide variety of situations. Because each level of responsibility has its own requirements, competence can occur in

any period of a person's life or at any stage of his or her career (“Competence,” n.d., para. 1).

Just prior to a new Chief Executive Officer (CEO) being hired in the spring of 2013, the organization changed its structure and a new executive and leadership team (Menno Place, 2017a; see Appendix B) were put into place. As the new person in charge, the writer soon realized that executive leaders, managers, and directors had been hired or moved into cross-site roles and that four companies with distinct cultures and philosophies were now expected to work as one. Leaders had received no formal preparation, exhibited limited systems thinking, and were expected to cope with their new roles and changing expectations. An assessment of the organization’s readiness for a shift to PCC and a change in culture began in May 2013.

It soon became apparent that the experience from a previous change initiative had left people distrustful, cautious, and resistive to change. The writer recognized the need to support and mentor executives, directors, and managers to foster leadership competency development to ensure they would be successful in moving MP forward.

Evidence from the Literature

A literature review was conducted on the topics of person-centred care, culture and change, leadership and leadership development. Each of these topics is explored in the subsections that follow.

Person-centred care. Person-centred care was researched to determine what processes the leadership team of MP should use to successfully adopt a person-centred care philosophy. (Although the term RFCC has evolved in the LTC sector, most of literature reviewed used the term PCC.) The following subquestions supported the writer’s understanding and process of adopting person-centred care:

1. What is the current definition of PCC or RFCC?
2. What actions are required by leaders to lead staff to adopt PCC or RFCC and shift the organizational culture to the RFCC?

Person-centred care is a term increasingly used in healthcare in the 21st century, and there is no standard definition (AGS, 2016; Han, 2016; Morgan & Yoder, 2012; Bender, Lui, Holyoke, 2017; Brownie & Nancarrow, 2013). The term person-centred care is used frequently in residential care facilities, and its interpretation and adoption methods can be seen in many different forms (American Geriatrics Society Expert Panel on Person-Centered Care [AGS], 2016, p. 15; Li & Porock, 2014, p. 1395; Morgan & Yoder, 2012, p. 6). One interpretation of person-centred care is "a philosophy that focuses on the individual rather than on the condition, and on the person's strengths and abilities rather than losses" (Alzheimer Society of Canada, 2011, p. 10). In 2014, the BCMOH set person-centred care as its top priority to achieve efficiencies in the BC healthcare system and in 2015 a framework for person-centred care was released. Culture change is the direction needed to achieve person-centred care. This philosophy needs to be adopted from the top of the organization and made part of its mission and vision. It is not a program for a specific department, but rather an organizational change that impacts how the entire organization operates. The organizational culture must shift in order for person-centred care to success.

Culture and the role of leadership in culture change. Literature on culture change indicated that the adoption of a new organizational philosophy requires a whole culture transformation. Leading culture change, assessing staff readiness for culture change, and sustaining culture change were areas identified as requiring literature analysis (Britton, 2010; Crandall, White, Schuldheis & Talerico, 2007; Fox, 2007; Goffee & Jones, 2000; Gordon &

Stryker, 1994; Harvey & Brown, 1996). Weiner and Ronch (2003) noted, "Leaders of culture change in a long-term care setting should therefore prepare for an ongoing and complex process with an open-ended series of stages characterized by personal and organizational growth" (p. 23). Kotter (1996, 2007, 2014) designed the change theory that MP chose to implement for its cultural shift. In his theory, Kotter (2014) spoke about eight "accelerators" (p. v) that drive change: create a sense of urgency, build a guiding coalition, form a strategic vision and initiatives, enlist a volunteer army, enable action by removing barriers, generate short-term wins, sustain acceleration, and institute change. MP used Kotter's theory as it reflected many of the same concepts that leadership had learned in the LEADS (Dickson & Lindstrom, 2008) training.

The literature reviewed indicated the need for ongoing personal development for leadership growth (Jackson & Parry, 2011; Kouzes & Posner, 2002; Lawrence, 2014; Quinn, 2004). Research "suggests that effective implementation of organization-wide change in nursing homes is associated with high-quality management communications about the change, organizational readiness for change, and favorable perceptions from direct care providers about the priority of the innovation to the organization" (Rosemond, Hanson, Ennett, Scheneck & Weiner, 2012, p. 262).

Bowers et al. published a research paper published in 2007 on the subject of implementing change in long-term care; these authors defined the "good" (p. 23) qualities of leaders as being able to "provide direction, … lead courageously, … influence others, … foster teamwork, … champion change, … coach and develop others, …motive and inspire others, … [and] build relationships (p. 24). The literature indicated that leadership development is needed for culture change.

Leadership development for change management. Literature was reviewed to determine a model that could be used to develop leadership capabilities (Schein, 1992; Senge, 2006; Stubblefield, 2005; Rowe, Graf, Agger-Gupta, Piggott-Irvine, & Harris, 2013; Zenger, 2014; Zenger, Folkman, Sherwin, & Steel, 2012). Grenny, Patterson, Maxfield, McMillan, and Switzler (2013) asserted, "What qualifies people to be called 'leaders' is their capacity to influence others to change their behavior in order to achieve important results" (p. 6). The LEADS framework has been developed and revised based on thorough research. Graham Dickson and Bill Tholl, in their 2014 book titled *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, discussed five themes they had examined: (a) change demands skilled leadership; (b) leadership is an acquired ability, (c) a shift in vision requires a shift in leadership, (d) leadership—and its development—are disciplined activities, and (e) leaders need a whole systems view. They also talk about the fact that "there is no one-size approach to leadership" (Dickson & Tholl, 2014, p. 176).

Jim Clemmer (2013), renowned author and speaker, wrote a paper titled *Leadership Competency Models: Why Many are Failing and How to Make Them Flourish*. In this white paper, Clemmer states, "Leadership competency models can provide a structured framework for defining and developing those behaviors that have the biggest impact on an organization's performance" (p. 1). However, he goes on to state, "There is a decades-long history of failed organization initiatives" (Clemmer, 2013, p. 1). Clemmer indicated that there are six principal reasons for failure. One of the main reasons is that some models appear to pick the competencies out of "thin air" (Clemmer, 2013, p. 1). David L. Cooperrider (as cited in Creelman, 2001) stated,

> It could be argued that all leadership is appreciative leadership. It's the capacity to see the best in the world around us, in our colleagues, and in the groups we are trying to lead.… It's the capacity to see with an appreciative eye the true and the good, the better and the possible (p. 1).

The LEADS framework (Dickson & Lindstrom, 2010) was chosen as it was developed for the healthcare environment. Furthermore, the writer had successfully worked with the LEADS framework in two other organizations.

Approach

The writer completed individual interviews and met with focus groups of managers and directors to learn their perceived causes of the failure of a 3-year culture change initiative undertaken in 2007. The unsuccessful culture shift involved the implementation of the Eden Alternative® (n.d.), a popular approach that has been successful in a number of LTC homes. An appreciative inquiry from that experience provided guidance as MP moved forward with its new project. LEADS training (Dickson & Lindstrom, 2010) was implemented and Kotter's (1996, 2007) theory was used to drive the change.

LEADS training. The writer's decision to use the LEADS framework (Dickson & Lindstrom, 2010) to expand leadership capabilities was based on past experiences in which changes were successfully implemented by the writer in two other organizations. As an active member of the Canadian College of Health Leaders (CCHL), the writer had personally committed to using the LEADS framework in organizations in which the writer has influence. First, LEADS was discussed with the MP executive team to obtain their support. The Director of Human Resources led the implementation and organized facilitators to do the training.

Education on leadership capabilities began for the MP leadership team between February and April 2014 using the domains of the LEADS framework (Dickson & Lindstrom, 2010) to develop an awareness of and a common language regarding their leadership capabilities. The training time helped to solidify the new team and allowed for discussion about the new RFCC vision for MP. The five LEADS domains—Leads Self, Engage Others, Achieve Results, Develop Coalitions, and Systems Transformation (Dickson & Tholl, 2013)—appeared to answer the learning needs for what had been challenges in the failed project. The 20 capabilities within the domains are the capabilities that the MP leadership team has embraced. Graham Dickson and Ed McKenzie, facilitators engaged through the CCHL, were used as educators for this project. A follow-up session was facilitated by Ed McKenzie in June 2015 to ensure the lessons learned were still being applied and understood. The Director of Human Resources and the CEO attended a LEADS conference about next steps in the journey in October 2016, and the Executive Director of Finance and Operations presented MP's experience at the June 2017 LEADS workshop. The team's leadership capabilities were reassessed in 2015; the writer found the results from this assessment to be encouraging, as leaders' scores, according to their reflections, had improved (see Appendices C and D). The writer plans to continue to monitor the capability development of the MP leadership team using this tool.

Kotter's change theory. A structured change management process was used to support leaders in taking specific actions toward the organization's goals. Triads and small quality improvement groups worked on identified tasks related to shifting the culture to RFCC. As competency gaps were identified leaders were coached, supported, and/or educated as MP moved forward. Our leaders continue to identify additional tools and actions they need to help shift the culture. MP leaders continue to test and implement their change ideas and document the

results. They are reflecting on how their processes evolve and how they, as leaders, are managing the shift. As barriers are encountered, the MP executive team brainstorms and strategizes how to assist the leadership team.

Results

An identified obstacle to the success of the Eden Alternative® (n.d.) project was the lack of support visible by the CEO and managers. Kotter (1996) noted, "Major change is often said to be impossible unless the head of the organization is an active supporter" (p. 64). Kotter (1996) went on to state, "Individuals alone, no matter how competent or charismatic, never have all the assets needed to overcome tradition and inertia except in very small organizations" (p. 64). The leaders reported that they personally did not buy into the change initiative, in spite of the amount of training about the new program and resources expended. The CEO did not set clear expectations for participation, so many leaders opted out. The number one issue they reported as the cause for failure of Eden Alternative® (n.d.) was the lack of a common vision and understanding of the reasons to embrace the new philosophy. Leaders cited an across-the-board complacency, resistance with sabotage, and a lack of personal commitment to the project. The leaders were not connected to the new path.

In September 2016, each of the 12 Menno Place (MP) leaders received a 360-degree performance evaluation using online software (see Appendices C and D). The leaders evaluated themselves, one another, and their direct reports. The executive team also evaluated each leader. The leaders described that they felt they had seen an improvement in their leadership capabilities since their reported self-evaluations in 2014. (The original self-evaluation results were not tabulated nor retained during this project.)

The results of the 2016 tool to measure the eight leaders at a director or manager level, were categorized into 14 sections: professional and technical knowledge, leadership, managerial skills, teamwork, quality orientation and service excellence, planning and problem-solving, resource management, respectful relationships, collaboration, interpersonal credibility, pursuit of excellence, communication and negotiation skills, and commitment to caring and development potential. MP leadership found the results to be very encouraging and will use them as a baseline going forward.

The four members of the executive team were evaluated under the following categories: strategic orientation, organizational awareness, impact and influence, relationship building, commitment to continuous learning, managerial skills, leadership, teamwork, collaboration, planning and problem-solving, respectful relationships, resource management, interpersonal credibility, commitment to learning, communication and negotiation skills, and pursuit of excellence. Using different competencies for directors and managers compared to executive leaders appears to make the information more applicable and meaningful.

The results in individual competencies for the directors and managers ranged from 3.4 to 4.7 out of a possible 5. The two most junior leaders scored the lowest over all. For the executive team, the results ranged from 4.0 to 4.7. It is evident from the tool used that the least experienced executive leaders also scored lower than more experienced leaders. The results also showed that each leader has different strengths and weaknesses. Through working as a team, MP leaders can maximize their effectiveness using this information.

The Accreditation Canada Worklife Pulse tool (Sounan, Lavigne, Lavoie-Tremblay, Harripaul, Mitchell, MacDonald, 2012) was used in April 2014 to measure employee engagement and employee health in MP and is repeated yearly. Results in 2014 indicated that

MP's communication systems needed improvement and that staff were experiencing high levels of stress and anxiety. A specific question related to the staff's perception of senior management, and results showed that many staff indicated that they did not know who the senior leaders were. The subsequent results have shown an increase in trust of the leaders and the organization. The staff engagement scores have also improved.

Communication and Negotiation skills were the lowest scoring category for the managers and directors, whereas the executive leaders scored lowest in "Strategic Orientation." The LEADS framework (Dickson & Lindstrom, 2010) covers these competencies in the domains of Achieve Results and Engage Others. It appears that Communication and Negotiation are the most challenging competencies for both teams. Three of the leaders are currently engaged in formal education programs, including a Health Leader Master of Arts in Leadership, and a certificate program for leadership as part of the Leads Self domain.

Discussion

Reflecting back on the past initiative allowed a time of debriefing and letting go of feelings related to the Eden Alternative® experience. This also provided information that informed where the new change management process would need support. Using the LEADS framework (Dickson & Lindstrom, 2010) as a methodology to discuss capabilities enabled leaders to learn together, to determine how to support each other, and to articulate to their executive leader where they needed help. Having time together to brainstorm ideas of how to proceed with their parts of the project created a synergy of collaboration. Application of the Kotter's (1996, 2007) theory of change offered a clear framework for driving the culture change.

Lead self. Dickson and Tholl (2014) noted, "Successful leadership must be solidly grounded in who you are" (Dickson & Tholl, 2014, p. 57). The Leads Self domain includes the

following capabilities: being self-aware, managing themselves, developing themselves, and demonstrating character (Dickson & Tholl, 2014). As the MP leaders did the work to learn this domain, they learned about themselves and about each other. They learned about the differences between managing and leading and were taught the five practices of leadership: "model the way, inspire a shared vision, challenge the process, enable other to act, and encourage the heart" (Kouzes & Posner, 2007, p. 3). For leaders, time spent with each other was vital, as it enabled them to get to know one another and begin to trust each other as leaders with their new CEO as a new 14-person team. During the LEADS training session it became apparent that two leaders were not engaged with the rest of the group. These two individuals left the organization after they self-identified that they were not a good fit for the vision.

To foster leadership development within the organization, MP was the first employer in BC to sign a formal strategic alliance in October 2014 with the CCHL to commit to encouraging leaders to attain their Certified Health Executive™ (CHE; CCHL, n.d.) and to use the LEADS framework (Dickson & Lindstrom, 2010) for leadership development. The Lead Self domain has inspired four leaders to develop themselves over the past 2 years by working to complete degrees at a master's or bachelor's level and by working towards attaining their CHE status with the CCHL. One executive leader completed a Master of in Arts in Leadership degree at the Royal Roads University in August 2017 to further develop her leadership capabilities.

Engage others. The changes that were made during the Eden Alternative® (n.d.) project were lost within a very short time as the culture shift was not consolidated into new staff approaches. When the leadership changed the staff and managers returned to the way they used to work before Eden Alternative®; consequently, the writer found no signs of elements of the Eden Alternative® project when she took up her position in May 2013. Organizational charts had

returned to how they had previously been, position titles were renamed, and environmental changes were reversed. Anchoring a change within a culture requires a broad-based approach in which communication and changes occur at all levels. New approaches need to be firmly planted to take root within an organization. Frankel et al. (2017) noted, "The number one change to improve perceptions of management is to increase the visibility of leader" (p. 7).

The LEADS framework (Dickson & Lindstrom, 2010) describes the capabilities in the Engage Others domain as fostering the development of others, contributing to the creation of a healthy organization, communicating effectively, and building teams (Dickson & Tholl, 2014). Dickson and Tholl (2014) defined engagement in healthcare organizations as "the degree of constructive interactivity between a leader and a follower aimed at achieving a shared vision of quality patient care in a sustainable universal health system" (p. 79).

The plan that was developed to increase visibility of senior leadership improved their engagement with employees. Walk-abouts were implemented, the CEO held town hall meetings with staff, the executive team began to eat in the staff café, departments were restructured, unit meetings included invitations for senior leaders to attend, and a communication strategy using a new staff electronic newsletter, Facebook (n.d.), Twitter (n.d.), and email was started. Dickson and Tholl (2014) noted, "Leaders who walk around, who are visible and mentally present, are much more able to engage with staff" (p. 86).

The reporting structure for the Reception staff was changed to bring them together under one leader, as they were seen as key to MP's new model for customer service in four different buildings. Previously, each receptionist had reported to a different leader with minimal supervision.

Leaders strategized how they would become more visible to staff. MP moved the office of one executive leader to encourage face-to-face opportunities for staff engagement. Another restructuring change was to relocate previously isolated Finance department staff to where their leader was.

The Director of Human Resources developed and implemented an employee wellness plan with the Occupational Health and Wellness Committee. Leaders model wellness for their staff and encourage healthy living practices such as hand hygiene, immunizations, blood pressure monitoring, working out, and healthy eating to increase their visibility. An Absenteeism program was implemented to increase connectivity to staff. Overtime, sick time, and workplace injury indicators are monitored and used to guide programs. To decrease the anxiety caused by an active rumour-mill, the CEO holds face-to-face meetings with all staff at times of major change and keeps an ongoing dialogue with union and association representatives.

The current change process is supported by a very thorough communications strategy. A new position was developed, Director of Communications and Stakeholder Engagement, which ensures that a high level of expertise is used to send messages out and elicit feedback. Ongoing measurements are made of the effectiveness of electronic media messaging.

Achieving results. The people interviewed said there were few short-term wins in the Eden Alternative® project; as such, people became discouraged with nothing to celebrate. Weiner and Ronch (2003) warned, “The major reason that significant culture change fails is that leaders don’t allow sufficient time to achieve each step before moving on to the next one” (p. 69). A change strategy must include short-term goals that are achievable, measurable, and can be celebrated along the process.

Dickson and Tholl (2014) noted, “The Achieve Results is the most task-oriented of the five capabilities of the LEADS framework” (p. 101. The Achieve Results domain includes the following capabilities: set direction, strategically align decisions with vision, values and evidence, take action to implement decisions and assess and evaluate (Dickson & Tholl, 2014). To influence others, a leader must be able to paint a clear picture about the vision for the future. Leaders must be able to measure the changes being made to know that they are succeeding.

The team was familiar with the plan-do-study-act process from the Institute for Healthcare Improvement, but this approach had not been commonly applied across the organization. Each leader developed a purpose statement and a personal goal related to RFCC, which the leaders then shared with one other. Early into the leadership development for MP a new expectation was set that all leaders would be accountable for identifying and submitting two departmental goals designed to shift our culture, goals which were measurable and would be shared with the leadership team, so leaders could support each other in reaching goals that would move the organization forward. The training helped leaders learn how to make goals measurable and meaningful. Goal setting was a new skill that many had not been expected before. The new CEO mentored the executive team so they were clear about the expectations and could, therefore, coach their leaders. The RFCC initiative has been introduced slowly with inclusion of all leaders. Time has been taken to ensure that each leader understands his or her role in the vision. MP Leaders continue to share their goals every six months and celebrate their accomplishments. Setting goals and measuring their attainment helps set the direction for a change initiative. Focusing on a few key behaviours to change helps the leaders to ensure success. The new leadership team takes time each month to celebrate “What we are proud of” and their progress.

Slideshow presentations are prepared to reinforce the progress in a visual way to each other, and are often shared with the Mennonite Benevolent Society Board.

Develop coalitions. Another difficulty encountered in the Eden Alternative® (n.d.) experience was that new plans were "dropped onto the table" without regard for the effect on others. The result was confusion, mixed messages, and inertia. The more that changes were forced onto people, the more they became defensive or resistive, morale went downhill, people did not make needed sacrifices, and good leaders left the organization. The leaders reported there was no team effort in place to drive the change. As an internal coalition was lacking, there were insufficient numbers of people working together to move the project forward; thus, the culture could not shift.

The Develop Coalitions domain has the following capabilities: purposefully build partnerships and networks to create results, demonstrate a commitment to customers and service, mobilize knowledge, and navigate the socio-political environments (Dickson & Tholl, 2014). From an external coalition perspective, work began in a formal way to improve the partnership capability of the organization. It was a new expectation that all leaders would be encouraged to look outside of the organization to develop strategic partnerships. MP had been relatively insular, and leaders were not encouraged to look outside of Menno to develop coalitions. An interesting project emerged with school groups and family members invited to discuss redesign of the MP Special Care Unit. Although the process slowed the work down, learning this co-design format assists leaders as they go forward in our future redevelopment of the campus. MP's networks have expanded as executive level staff have formally become involved participating as board members with associations in the industry and faith-groups such as the BC Care Providers Association, SafeCare BC, the Mennonite Central Committee and the Mennonite Church of BC.

System transformation through effective leadership. Kotter (1996) asserted, "Leadership defines what the future should look like, aligns people with that vision, and inspires them to make it happen despite the obstacles" (p. 23). In the Eden Alternative® (n.d.) project, managers were working hard managing, but they were not given the tools to provide leadership to the organization. Leadership is essential to be successful in transforming a culture:

> Managing change is important. Without competent management, the transformation process can get out of control. But for most organizations, the much bigger challenge is leading change. Only leadership can blast through the many sources of corporate inertia. Only leadership can motivate the actions needed to alter behavior in any significant way. Only leadership can get change to stick by anchoring it in the very culture of an organization. (Kotter, 1996, p. 24)

The capabilities of the Systems Transformation domain are demonstrate system and critical thinking, encourage and support innovation, orient strategically to the future, and champion and orchestrate change (Dickson & Tholl, 2014). Dickson and Tholl (2014) noted, "Even though there has been a societal consensus around the promise of patient-centred care, leaders must still bring it about by supporting changes to everything from how providers and the system work to the culture they work in" (p. 140).

This has been MP leadership's most challenging domain, although leaders have seen wonderful progress. MP has even seen successes such as winning two prizes for innovation: one for implementing a chemical-free cleaning system for the environment and one for designing and building a purpose-built laundry-hauler to reduce the possibility of staff injury. A system-wide change occurs by many small changes amounting to a huge shift. The first capability, critical thinking, has been the most challenging step to coach and inspire. Leaders are slowly learning to

measure, examine, and reach outside the organization to see where they can make system changes.

Focusing on skills and behaviours that all leaders exhibit to some degree was a positive competency builder. Clemmer (2013) stated, “Leaders who focus on their weaknesses consistently create weaker development plans, allocate less of their time to personal growth, and abandon training efforts more quickly” (p. 2). He went on to say, “In one study we found that executives working on weaknesses reported their leadership improvement efforts had minimal impact on business results and even less effect on the commitment or engagement levels of their direct reports” (Clemmer, 2013, p. 2).

The leadership team at MP is now building on the momentum from this project to continue shifting the culture to be person directed. As MP leadership celebrates steps toward its goal, the short-term wins encourage leadership team members and staff. For example, leaders have focused on decorating projects that brighten and liven up living areas. These visible improvements have provided hope and encouragement to staff. Making visible wins of the culture change is a strategy that others could learn from. These wins encourage others to become involved, as it honours those with the ideas that are incorporated.

The key to a successful shift in culture is a team of leaders with the energy and passion to motivate and lead staff. The LEADS framework (Dickson & Lindstrom, 2010) training process fostered time for leaders to create a synergy together as they learned about developing coalitions are work. With the team solidly on board regarding the need for a culture shift, MP was able to create an urgency to begin and drive the project. There was clear direction from the board and the CEO that MP was to move to become a person-centred organization. Leadership has been coaching staff to think in new ways and to step out of their comfort zones. At times, leaders have

been tested by staff resistance. The informal relationships between staff sometimes create barriers to change. MP leaders have learned that resistance often reflects a fear of the unknown or a fear of the loss of power. Consistent messaging from all of the leaders and working together to move the resistors forward is showing progress. Regular meetings with staff and face-to-face discussions have helped to increase the clarity of the vision. A restructuring of the nursing leadership team-put leaders with high-scoring capabilities in place where the most challenging staff were encountered.

As MP leaders created a guiding coalition, the stakeholder engagement increased. The staff soon realized that they heard the same vision from all leaders and that they could no longer ignore the direction the organization was heading. Leadership included residents and family members in some of the culture shift projects. This again broadened the coalition and helped to drive the change. A specific project also used enthusiastic students from an art design college. Other organizations are encouraged to broaden the coalition base for major cultural shifts, as it has been much more successful than the previous project, which was driven by one individual. MP leadership believes that our team has the authority, the trust and the enthusiasm to move mountains.

Lessons Learned

Setting clear expectations for this initiative appeared to clarify the importance of the learnings. It was clear from the outset that leaders were to attend the LEADS training and participate. The homework assignments were also to be completed. This clear direction from the CEO appeared to strengthen the commitment of the group to the project. MP leadership expressed enthusiasm, and people seemed to appreciate that the organization had invested

resources in them. The only two people who did not engage with the process left the organization shortly after the training was completed.

Learning the common language of the competencies and domains of leadership built a foundation for working together. Leadership's first step toward success was having the leaders embrace the LEADS model and framework (Dickson & Lindstrom, 2010). As MP leaders travelled on this journey, discussion of the LEADS domains assisted the organizational leaders to identify multiple activities they wished to undertake to ensure that they were, indeed, *demonstrating* the behaviour that each domain recommended. The leaders who participated in the training continue to use the concepts they learned. Two new leaders have been hired since the training; they have received training on the LEADS framework. Skills training has given the leaders practice in how to apply the framework capabilities. Each leader has a laminated copy of the capabilities mounted on an office to remind the leader of the elements.

Regular practise using the LEADS language and regular review of application of the framework assisted the leaders in retaining the learning. The LEADS framework was found to be understandable, relevant and motivating for the team. The team members committed to personal development plans that are exhibiting positive outcomes. Continued focus on the use of this framework is providing measurable results.

The teamwork that was built during the education process helped to compound the success of the competency development. Working together, the group was energized and motivated to move the organization forward. As the team was energized, they had the enthusiasm to go out and inspire their own teams to achieve difficult goals and increase their performance. Instead of just accomplishing tasks, they began to paint pictures of a new future. Although we are moving forward slowly, people are beginning to release their resistance to change.

People who had exhibited hesitation and appeared distrustful of the new executive team began to walk with us. These individuals had expressed that they had not trusted the previous change process. As we got to know each other better we began to understand our shared aspirations and dreams for the organization. Trust built a willingness to change together. As trust started to develop, friendships were also started. People began to have lunch together. Being honest and acting with integrity helped to foster respect for each other. Respect supported a willingness to collaborate more instead of working in silos.

As the leadership team was becoming more cohesive, it was interesting to see two individuals self-select to leave the organization. It was clear that they did not fit and that they weren't comfortable with the new relationships that were developing. They continued to want to see the new executive team fail. They no longer had support for their negativity. As the other leaders became enthusiastic for the new sense of direction and energized to move the organization, those two individuals could no longer resist the forward momentum.

MP continues to monitor and track our successes with the LEADS framework implementation. We use LEADS on line evaluations as coaching tools with our leaders.

Empowering leaders, staff, residents and family members has helped us to knock down obstacles to our culture shift. Facing people's anxiety with calm resolve and listening to them has given time to develop strategies to mitigate resistance. Building trust has encouraged staff to become risk takers. Our leaders have become key supporters of the culture change instead of resistors.

As MP leadership consolidates the changes they make into gains, the leadership team increases their credibility with the staff and trust for future projects has increased. As the staff see positive outcomes in their workplace and for the residents, they are more willing to anchor

the expected new behaviours and approaches into practice. This also helps the new culture to become the norm.

Limitations and Future Work

One significant limitation of this study was the inability to concretely measure pre and post leadership competency scores. As leaders further develop their skills and behaviours, they can then focus on the development of competencies within all levels of their workforce. Identification of the strengths and capabilities of employees allows leaders to coach and mentor staff to their full potential. At the same time, MP leadership recognize that different competencies may need to be identified for bedside or other support staff.

This project used the LEADS framework (Dickson & Lindstrom, 2010) as a basis for the building of leadership skills and knowledge. A comparison of other leadership frameworks may suggest that other models may fit different levels of employees better. For instance, under the domain of Develop Coalitions is the "navigate sociopolitical environment" capability; this may not apply to employees who do not work outside the organization in their role.

When future work is undertaken about emerging health leaders, particularly those that are younger, new competencies may be required to combat perceptions that impact them as leaders. Zenger and Folkman (2015b) have found that younger leaders encounter challenges, such as not being fully trusted, lacking experience and deep knowledge, not being perceived as a role model, being insensitive to others' needs, not being capable of representing the organization, and lacking strategic perspective. These challenges may lead to the need for fostering different capabilities, and/or for different training.

MP leaders continue to work on the organization's vision and strategy to clarify where MP is going with RFCC. A recent presentation by another organization about "person-directed"

care has inspired MP leadership to re-examine the MP vision. Reclarifying the vision will help us drive the change effort. As MP leaders bring other stakeholders, including family members into their discussions, they will find ways to remove barriers. The writer encourages other long-term care organizations to broaden their stakeholder involvement when they wish to shift their organization's culture. One of the most effective ways in which MP leaders have communicated we are hearing what families say is by acting on their suggestions. Modelling the behaviour that leaders are listening and that we want them to come to us with ideas has been very effective in getting their buy-in for future initiatives.

The writer's personal career experience has been that administrators often expand leadership roles by requesting that managers transform processes in an increasingly complex environment without reflecting on what tools those managers might require to do what is asked of them. As such, leaderships ask them to participate in creating thriving organizations while shifting from the very culture they have helped developed or have worked in.

Implications and Knowledge Translation

The results of this project show that formal investment in competency development for leaders can have a positive result in the success of culture change in a relatively short time. Regular leadership coaching builds the capacity of each individual and in the long run enhances the productivity of the organization. Administrators in LTC settings need to invest in leadership competency development to support their leaders, and not just presume that because they have been doing a job that they have the capabilities to lead well.

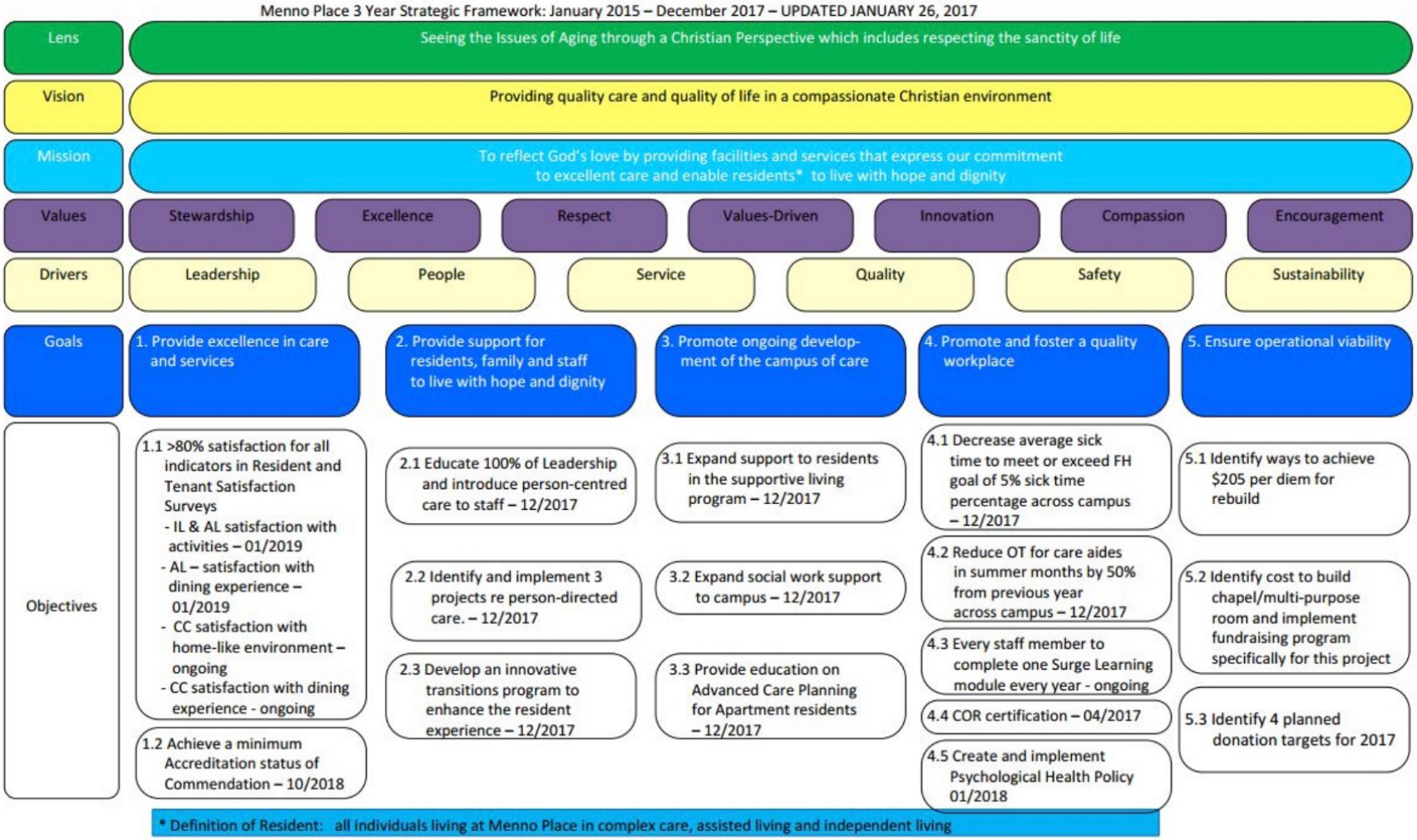
Using a tested leadership competency model is likely to be a more effective strategy than using random competencies. In the MP project, the expert facilitation by Graham Dickson and

Ed McKenzie aided the uptake and understanding of the LEADS domains and the competencies. This approach proved to be a wise investment.

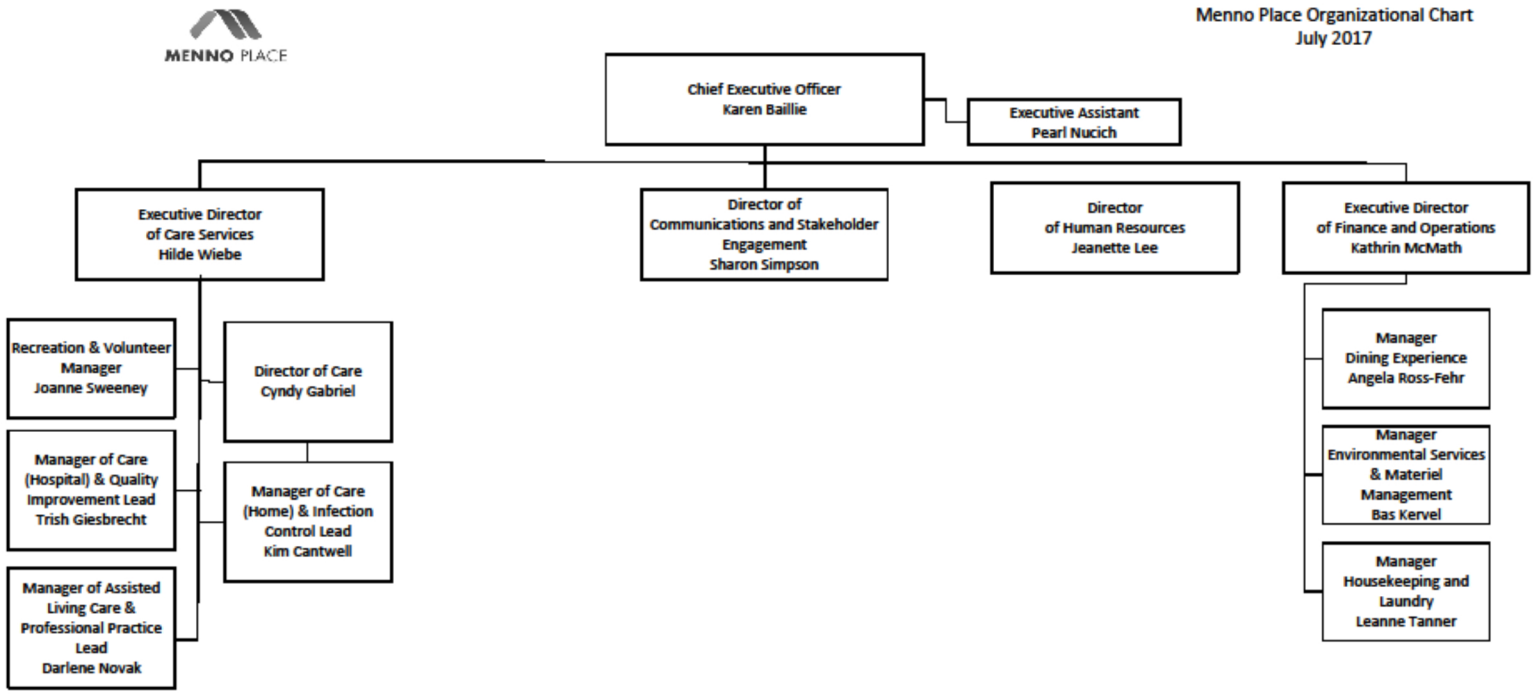
MP leadership has demonstrated through the Accreditation Canada (Sounan, Lavigne, Lavoie-Tremblay, Harripaul, Mitchell, MacDonald, 2012) Worklife Pulse tool that leadership development appears to lead to improved employee engagement, retention, development, and performance. It also leads to improved job satisfaction for the leadership team. Finally, it enables culture change. These are important messages for health leaders in all roles and sectors.

MP's experience suggests that leadership competency development is particularly necessary for younger leaders. The two leaders who scored the lowest during the MP project were younger and less experienced than their colleagues. Based upon the results of this project, it is suggested that leadership competency development be applied, particularly to younger leaders, as they would have less learnings from experience. The success of a culture change initiative is contingent upon *all* leaders having the appropriate knowledge and skills to lead their staff. As leaders develop their own skills and behaviours, they can then focus on the development of competencies within all levels of their work force. Identification of the strengths and capabilities of employees allows leaders to coach and mentor them to their full potential. Leaders must be visionary, effective, and efficient in leading. Just knowing how to do a job does not qualify a person to lead others.

Appendix A: Menno Place 3-Year Strategic Framework: January 2015 – December 2017



Appendix B: Menno Place Leadership Team July 2017



Appendix C: Leadership Capabilities of Executive Team

Each leader did a self-evaluation ranking themselves on a number of questions on a scale of 1 to 5. The results were categorized by the software into the leadership competencies below.

Leadership Capability	Leader 1	Leader 2	Leader 3	Leader 4	Average	Range
Strategic Orientation	4.4	4.0	4.5	4.2	4.275	4.0 to 4.5
Organizational Awareness	4.4	4.2	4.4	4.1	4.275	4.1 to 4.4
Impact and Influence	4.5	4.3	4.4	4.4	4.400	4.3 to 4.5
Relationship Building	4.4	4.3	4.4	4.3	4.350	4.3 to 4.4
Commitment to Continuous Learning	4.4	4.4	4.6	4.3	4.425	4.3 to 4.6
Managerial Skills	4.5	4.4	4.5	4.5	4.475	4.4 to 4.5
Leadership	4.6	4.5	4.7	4.5	4.500	4.5 to 4.7
Teamwork	4.7	4.6	4.5	4.6	4.600	4.5 to 4.7
Collaboration	4.5	4.4	4.4	4.2	4.375	4.2 to 4.5
Planning and Problem-Solving	4.6	4.3	4.4	4.5	4.450	4.3 to 4.6
Respectful Relationships	4.6	4.5	4.5	4.4	4.500	4.4 to 4.6
Resource Management	4.7	4.0	4.5	4.7	4.475	4.0 to 4.7
Interpersonal Credibility	4.7	4.5	4.6	4.5	4.575	4.5 to 4.7
Commitment to Learning	4.6	4.7	4.6	4.7	4.650	4.6 to 4.7
Communication and Negotiation Skills	4.4	4.5	4.6	4.4	4.475	4.4 to 4.6
Pursuit of Excellence	4.5	4.5	4.8	4.5	4.575	4.5 to 4.8
Total	**72.5**	**70.1**	**72.4**	**70.0**		

Appendix D: Leadership Competencies of Directors and Managers

Each leader did a self-evaluation ranking themselves on a number of questions on a scale of 1 to 5. The results were categorized by the software into the leadership competencies below.

Leadership Capability	Leader 1	Leader 2	Leader 3	Leader 4	Leader 5	Leader 6	Leader 7	Leader 8	Average	Range
Professional and Technical Knowledge	4.2	4.6	3.9	4.5	4.7	4.3	4.5	4.6	4.413	3.9 to 4.7
Leadership	3.6	4.5	3.9	4.3	4.7	4.3	4.6	4.5	4.300	3.6 to 4.7
Managerial Skills	3.8	4.5	3.8	4.5	4.6	4.1	4.5	4.4	4.275	3.8 to 4.6
Teamwork	3.8	4.5	3.9	4.5	4.7	4.4	4.6	4.6	4.375	3.8 to 4.7
Quality Orientation & Service Excellence	3.9	4.4	4.1	4.3	4.6	4.1	4.5	4.5	4.300	3.9 to 4.6
Planning and Problem-Solving	3.9	4.5	4.1	4.2	4.3	4	4.2	4.5	4.213	3.9 to 4.5
Resource Management	4.3	4.6	3.9	4.5	4.4	4.2	4.4	4.4	4.338	3.9 to 4.6
Respectful Relationships	4.0	4.4	4.0	4.6	4.7	4.5	4.7	4.6	4.438	4.0 to 4.7
Collaboration	3.7	4.4	3.8	4.3	4.4	4.1	4.4	4.4	4.188	3.7 to 4.4
Interpersonal Credibility	3.9	4.3	3.9	4.5	4.6	4.3	4.6	4.4	4.313	3.9 to 4.6
Pursuit of Excellence	3.8	4.5	4.1	4.3	4.6	4.3	4.5	4.6	4.338	3.8 to 4.6
Communication and Negotiation Skills	3.6	4.2	3.4	4.2	4.4	3.9	4.3	4.2	4.025	3.4 to 4.4
Commitment to caring	4.2	4.6	4	4.5	4.6	4.4	4.5	4.5	4.413	4.0 to 4.6
Development Potential	3.9	4.5	4.2	4.4	4.7	4.4	4.7	4.6	4.425	3.9 to 4.7
Total	**54.6**	**62.5**	**55.0**	**61.6**	**64.0**	**59.3**	**63.0**	**62.8**		

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